Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 28, 2016	2016_353589_0011	013953-16	Resident Quality Inspection

Licensee/Titulaire de permis

ROYAL CANADIAN LEGION DISTRICT 'D' CARE CENTRES
59 Lawson Rd TORONTO ON M1C 2J1

Long-Term Care Home/Foyer de soins de longue durée

TONY STACEY CENTRE FOR VETERANS' CARE
59 Lawson Road TORONTO ON M1C 2J1

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

JOANNE ZAHUR (589), JULIENNE NGONLOGA (502), SARAN DANIEL-DODD (116), STELLA NG (507)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): May, 12, 13, 16, 17, 18, 19, 20, 23, 24, 25, 26, 30, 31, June 1, 2, 3, 6 & 7, 2016.

The following critical incidents were inspected concurrently with the RQI: log #'s 007911-14 and #002414-15 related to resident to resident inappropriate touching and reporting certain matters to the Director, log #'s 008848-14 and #017126-15 related to duty to protect, plan of care and responsive behaviours, log #024624-15

related to staff to resident abuse, log #'s 026515-15 and #014541-16 related to resident to resident abuse, log #'s 028881-15, #030323-15 and log #014355-16 related to resident to resident inappropriate touching, and log # 014870-16 related to neglect and lack of dignity associated with toileting.
The following follow-up was inspected concurrently with the RQI: log #013820-16 related to the following compliance orders:
#001-annual retraining related to Resident's Bill of rights, Zero tolerance of Abuse and Neglect, Mandatory Reporting and Whistle Blowing Protection.
#002-organized programs required under section 8-16 of the Act, and
#003-to develop and implement Hydration program and staff training on the Hydration program.
The following complaints were inspected concurrently with the RQI: log#009392-15 an anonymous complaint related to the Executive Director cancelling Resident Council meetings, log # 020960-15 falls prevention, continence and bowel care and improper care, log #032412-15 related to staff shortages in the home, log #000974-16 an anonymous complaint related to improper care, sufficient staffing, housekeeping, unqualified manager for recreations and nepotism regarding the hiring of staff/managers, and log #011820-16 an anonymous letter to the Director related to staffing.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Associate Executive Director (AED), Director of Care (DOC), Food Services Manager (FSM), Social Worker (SW), Registered Dietitian (RD), Environmental Supervisor (ES), Physiotherapist (PT), Office Manager (OM), Recreational Lead (RL), Minimum Data Set-Resident Assessment Instrument Coordinator (MDS-RAI), Behavioural Support Ontario lead (BSO), Registered Nursing Staff (RN/RPN), Personal Support Worker(s) (PSW), Dietary Aide (DA), Housekeeping Aide (HA), Nurse Manager (NM), Laundry Aide (LA), Activity Assistant (AA), and Physiotherapy Aide (PTA).

During the course of the inspection, the inspector(s) conducted a tour of the home, observations of meal service, medication administration system, staff and resident interactions and the provision of care, record review of health records, staff training records, meeting minutes for Residents' Council and Family Council and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **15 WN(s)**
- **8 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 30. (1)	CO #002	2015_302600_0012	589
O.Reg 79/10 s. 68. (2)	CO #003	2015_302600_0012	502
LTCHA, 2007 S.O. 2007, c.8 s. 76. (4)	CO #001	2015_302600_0012	589

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are protected from physical abuse by resident #004.

In accordance with the definition identified in section 2(1) of the Regulation 79/10, "physical abuse" means the use of physical force by a resident that causes physical injury to another resident.

Record review of a critical incident system report (CIS) submitted in February 2016, revealed resident #004 struck resident #022 and resident #022 reacted by injuring resident #004.

Review of the Resident Assessment Instrument – Minimum Data Set (RAI-MDS) assessment dated September and March 2016, for resident #004 revealed the resident exhibits responsive behaviours.

Review of the progress notes from September 2015, to May 2016, revealed resident #004's behaviours included several responsive behaviours that he/she had been exhibiting towards other residents and staff. Behavioural Support Ontario (BSO) documentation revealed that resident #004 had been referred to the BSO team following an escalation in behaviours in September 2015.

Further review of the progress notes for resident #004 revealed he/she had been involved in the following altercations:
-January 2016, struck RPN #143 which caused discomfort and pain,
-February 2016, resident #004 struck resident #017, causing no apparent injury,
-February 2016, resident #004 in an identified gesturing motion, attempted to strike resident #017. Staff had documented that resident #004 appeared very angry,
-February 2016, the dosage of an identified medication had been increased as well as the timing of administration,
-February 2016, while in the dining room resident #004 struck resident #020 with no apparent injury sustained,
-February 2016, resident #004 struck resident #021 causing injury,
-February 2016, the dosage of a second identified medication had been increased and also the frequency of the as needed dose (PRN) had been increased,
-March 2016, resident #004 struck resident #019 with no injury sustained,
-May 2016, resident #018 reported to PSW #134 that resident #004 had hit him/her when he/she had tried to have a conversation with him/her and,
-May 2016, resident #017 had been sitting at the nursing station, visibly upset and reporting that he/she had been struck by resident #004 with no apparent injury sustained.

Interviews with staff #133 and staff #124 revealed resident #004 had been discharged from the BSO program in February 2016. Staff #133 further revealed that he/she had not been aware of several resident to resident altercations between February and May 2016.

Interview with staff #103 revealed due to resident #004's ongoing demonstration of responsive behaviours, the BSO team should not have discontinued their weekly assessments.

Based on the fact that there were several documented incidents of responsive behaviours with some resulting in injury to both residents and staff, and the BSO had discharged the resident from the program even though the resident continued to demonstrate responsive behaviours, the licensee failed to ensure the residents were protected from abuse by resident #004.

2. The licensee has failed to ensure that resident #004 had been protected from verbal abuse.

In accordance with the definition identified in section 2(1) of the Regulation 79/10, "verbal abuse" means any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

Record review of a CIS report submitted in September 2015, revealed resident #004 had been lying in bed incontinent. Staff #132 offered to wash and change the resident in the bathroom; however resident #004 was resistive and staff #132 was overheard raising their voice at resident #004 in a demeaning way.

Interview with staff #117 and staff #148 confirmed they had heard staff #132 raising their voice speaking in a demeaning way to the resident when suddenly they heard a noise and found resident #004 on the floor with an injury.

Interview with staff #132 confirmed providing care to the resident on the above identified dated, but denied raising their voice at the resident.

Interview with staff #102 confirmed resident #004 had been verbally abused by staff #132. Staff #102 further revealed that staff #132 had been disciplined and had not provided care to the resident since the incident.

LTCHA, 2007 s.19.(1) was issued as a compliance order (CO #004) during inspection #2015_302600_0012 on November 25, 2015, with a compliance order date of January 31, 2016. During the course of this inspection, inspector #502 identified three residents that had been physically abused.

Due to actual harm, the scope of residents affected and the previous compliance history, a compliance order is warranted [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

a) The most recent written plan of care for resident #028 indicated the resident had been

exhibiting responsive behaviours related to underlying health conditions and required monitoring at identified intervals. Staff members were required to document the resident's whereabouts on an identified checklist.

Review of the identified checklist revealed and interviews held with staff members #118, #136 and #137 confirmed that resident #028 had required and continued to receive monitoring at identified intervals.

Further interview with staff #103 confirmed that the plan of care did not set out clear directions in relation to the monitoring requirements for resident #028.

b) In September 2014, a CIS was submitted reporting to the Director that during a scheduled program, resident #030 had been observed touching resident #031 inappropriately. An internal investigation revealed that there had been no harm inflicted to resident #031 as a result of the incident. As per the CIS report, the long term actions put in place to minimize behaviours with resident #030 were to monitor the whereabouts of resident's #030 and #031 at identified intervals for safety and to ensure that resident #030 was not placed beside specified residents.

Review of the most recent written plan of care for resident #030 revealed he/she had displayed inappropriate responsive behaviours.

The interventions had not addressed resident #030's requirement for monitoring at identified intervals.

Review of the most recent written plan of care for resident #031 had not included interventions to monitor the resident's whereabouts for safety.

An interview held with staff #149 and staff #103 confirmed that the plan of care did not set out clear directions to staff and others who provided direct care in relation to monitoring the whereabouts of resident #031 for safety and resident #030 for safety towards specified co-residents. [s. 6. (1) (c)]

2. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

Record review of a CIS submitted in September 2015, revealed resident #004 was in bed

and had experienced incontinence. The resident had refused to be toileted and care to be given.

Review of the progress notes from September 2015, to May 2016, revealed resident #004’s had exhibited identified responsive behaviours to co-residents and staff.

Review of the specialized behavioural teams notes revealed resident #004 had not been part of the specialized behavioural program since returning from the hospital in December 2015.

Interview with staff #145, confirmed that identified responsive behaviours for resident #004 had been ongoing and believed that resident had continued to be assessed by the specialized behavioural team on weekly basis.

Interview with staff #103 revealed due to resident #004’s ongoing demonstration of responsive behaviours, the specialized behavioural team should not have discontinued their weekly assessments.

Interview with staff #133 confirmed the BSO team had discontinued assessing resident #004 because there had been no further indication that resident #004 had been exhibiting responsive behaviours after re-admission from hospital. [s. 6. (4) (a)]

3. The licensee has failed to ensure that the Substitute Decision Maker (SDM) for resident #052 had been provided the opportunity to fully participate in the development and implementation of the plan of care.

Review of resident #052's Three Month Medication Review (TMMR) dated January 2014, revealed an identified medication had been ordered by the primary physician.

Review of the January 2014, medication administration record (MAR) for resident #052 revealed the above mentioned medication had been initiated as per physician order.

Interview with resident #052's SDM revealed that he/she had not been informed of the new medication order and therefore had not been provided the opportunity to fully participate in the implementation of the plan of care. The SDM further revealed he/she had become aware of this medication after resident #052 had been transferred to another long term care home .

Review of progress note documentation dated January 2014, in resident #052's health record revealed an entry noting the TMMR had been completed but no reference that family had been notified of a new medication being initiated.

Interview with staff #145 revealed that it is the home's expectation that when a new medication is ordered they are to document in the progress notes that family had been notified. Staff #145 further revealed that he/she could not recall documenting in resident #052's progress note that he/she had notified the SDM.

Interview with staff #103 confirmed that family had not been informed of the new medication and therefore had not been provided the opportunity to fully participate in the development and implementation of resident #052's plan of care. [s. 6. (5)]

4. The licensee has failed to ensure that the care set out in the plan of care provided to the resident as specified in the plan.

The written plan of care for resident #005 revealed the resident had an area of altered skin integrity to an identified body area that required treatment to optimize healing. In May 2016, the identified area of altered skin integrity had been medically treated and the dressing order had been changed.

On an identified date in May 2016, the inspector observed staff #119 completing a dressing change for resident #005. Staff #116 was observed not providing the treatment as identified in the plan of care.

Interviews held with staff#119, staff #112 and staff #103 confirmed that the treatment had not been provided to resident #005 as specified in the plan of care.

The most recent written plan of care for resident #026 revealed that the resident had displayed responsive behaviours related to inappropriate touching of co-residents and/or staff inappropriately. The resident required monitoring at identified intervals of his/her whereabouts to ensure the safety of residents on the unit.

In February 2016, the licensee submitted a CIS reporting to the Director that resident #026 had been observed inappropriately touching resident #027.

Review of the monitoring checklist for the month of May 2016 and interview held with staff #125 revealed that the staff had been conducting checks of resident #026's

whereabouts at identified intervals. An interview held with staff#124 and staff #103 confirmed that the expectation for resident #026 had been monitoring of his/her whereabouts at identified intervals and that the care had not been provided to resident #026 as specified in the plan. [s. 6. (7)]

5. The most recent written plan of care for resident #026 revealed that the resident had displayed responsive behaviours.The resident required monitoring of his/her whereabouts to ensure the safety of residents on the unit on identified intervals.

In February 2016, a CIS was submitted reporting to the Director that resident #026 had been observed inappropriately touching resident #027.

Review of the monitoring checklist for the month of May 2016 and interview held with staff #125 revealed that the staff had been conducting monitoring checks of resident #026's whereabouts at identified intervals. An interview held with staff #124 and staff #103 confirmed that the expectation for resident #026 had been monitoring of his/her whereabouts at identified intervals and that the care had not been provided to resident #026 as specified in the plan. [s. 6. (7)]

6. In May 2016, the inspector observed resident #009 receiving a meal in his/her room. The resident had received a tray that contained a supplement for lunch.

Review of resident #009's most recent plan of care revealed the resident was identified to be at nutritional risk and that staff had been directed to provide a specified diet, nourishments as per menu rotation, two bottles of a supplement at the morning meal, and one bottle of an enriched supplement at at the midday and evening meals.

Interview with staff #147, revealed that resident #009 had not eaten solid food or drank any fluid except the supplements as his/her meal replacement.

Interview with staff #137 confirmed resident #009's daily food and fluid intake consisted of fluids only.

Interview with staff #127 revealed that resident #009's fluid requirements were close to 2000 ml daily. The staff #127 revealed that resident #009 should have been offered tray service for all meals as per the meal plan. Staff #127 confirmed resident #009 had not been offered meals and snack as per their plan of care. [s. 6. (7)]

7. The licensee had failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

Review of resident #012's most recent written plan of care revealed that since December 2015, resident #012 had displayed a new area of altered skin integrity to an identified body area.

Review of the assessment completed by the specialized skin consultant and physician orders revealed that resident #012 required to offload pressure on the affected area, and to wear a protective covering on the identified area of altered skin integrity at all times.

Review of the most recent written plan of care and kardex under the focus related to skin care had not been revised to reveal the use of a protective covering at all times to resident #012's affected area and to offload pressure.

Interviews with staff #117 and staff #103 confirmed that the written plan of care had not been revised when resident #012's care needs had changed. [s. 6. (10) (b)]

8. A CIS report was submitted to the Director regarding a sexual abuse that had occurred between two residents. In October 2015, resident #028 had been leaning towards resident #029 when staff #153 observed resident #029 touching resident #031 inappropriately.

Review of resident #029's health record and interviews held with the resident and staff #'s 118, 137, 116 revealed that there had not been any other incidents before or after the above mentioned incident. Resident #029 revealed that he/she had been attempting to push resident #031 back into the chair as he/she was leaning towards him/her and may have fallen.

Review of resident #029's most recent written plan of care revealed that monitoring of resident #029's whereabouts at identified intervals had been in place from the date of the above mentioned incident until May 2016. The monitoring intervention had not been documented in the resident #029's written plan of care.

Staff #'s 118, 137, and 116 confirmed that monitoring at identified intervals were no longer necessary and that the plan of care related to this had not been reviewed and revised for resident #029 when care needs had changed. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the home's Nutrition and Hydration policy dated November 2015, was complied with.

a) Review of the home's policy titled: Maintaining Proper Hydration and Nutritional Intake, dated November 2015, revealed the following;
- the interdisciplinary team is to ensure all residents receive a minimum 1500 millilitres (ml) of fluids in 24 hours unless on restricted fluid intake,
- a three day food and fluid intake monitoring record should be initiated for residents with any significant change,
- registered staff to complete the hydration risk assessment when residents' fluid intake drops below 50 per cent of their normal fluid intake for more than 24 hours but less than 48 hours and,
- a referral should be sent to the registered dietitian (RD).

b) Review of the home's Food and Fluid Intake policy dated November 2015, revealed registered staff on night shift had to review the completed food and fluid forms daily to ensure compliance and notify the day Nurse Manager (NM) for any required follow up.

In May 2016, the inspector observed resident #009 during a meal service in his/her room. The resident had received a meal tray that only contained a supplement with no other food or fluids observed.

Review of resident #009's most recent written plan of care revealed resident #009 had been assessed as being at nutritional risk. The staff had been directed to provide a specified diet, nourishments as per menu rotation, two bottles of a supplement at the morning meal, and one bottle of an enriched supplement at the midday and evening meals. There had been no documentation that indicated resident #009 had been meeting the daily minimum fluid intake requirements in a 24 hour period.

Review of resident #009's Nursing and Personal Record for Food and Fluid Intake from May 2016, revealed that staff had been documenting that resident #009 had full fluid intake at meals and on some days at snack time.

Interview with staff #147 revealed that resident #009 had not eaten solid food or drank any fluid except a supplement as his/her meal replacement for approximately a year. An interview with staff #137 confirmed resident #009's daily fluid intake had been the total of four bottles of a supplement and sips of soda throughout the day. The staff further stated that resident #009 had not been assessed for signs of dehydration or referred to the RD as per the home's policy.

Interview with staff #112 confirmed that he/she had not been notified about resident #009 not meeting the daily fluid requirement.

Interview with staff #127 revealed that resident #009's fluid requirements needed to be an identified amount daily. Staff #127 further stated that resident #009 fluid intake had been below his/her daily fluid requirement placing him/her at risk of dehydration and confirmed that the resident had not been referred to her/him for further assessment.

Interview with staff #102 confirmed that the above mentioned policy had not been complied with [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's Nutrition and Hydration policy revised November 2015, was complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that is reported was immediately investigated.

Review of a CIS report submitted February 2016, revealed that resident #004 had struck resident #022 and that resident #022 reacted by striking back and injuring resident #004. The incident was unprovoked and that resident #004 had exhibited previous incidents of responsive behaviours.

Review of the progress notes for resident #004 revealed an internal investigation had not been initiated following the above mentioned incident.

Interview with staff #102 confirmed the internal investigation had not been completed at the time of this inspection. [s. 23. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that is reported was immediately investigated, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
9. Disease diagnosis. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

The licensee has failed to ensure that the plan of care is based on an interdisciplinary assessment with respect to the resident's disease diagnosis.

Review of resident #010's laboratory results revealed the resident had tested positive for an identified infection.

Review of resident #010's most recent written plan of care did not include a focus on infection prevention and control related to the above mentioned findings.

Observations in May 2016, on two identified days by the inspector revealed infection prevention and control signage had not been posted and personal protective equipment had not been available at resident #010’s door.

Interview with staff #112 confirmed resident #010 had tested positive for an identified infection.

Interview with staff #114 confirmed that specimens taken of two identified body areas for resident #010 had resulted in results that had indicated infection and confirmed that these results should have been included in resident #010’s written plan of care. [s. 26. (3) 9.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care is based on an interdisciplinary assessment with respect to the resident's disease diagnosis, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

The licensee has failed to ensure that the staffing plan is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Review of the home's staffing plan revealed a staffing quota for each resident home area (RHA) on each shift. The staffing plan also revealed the process the home staff should adhere to when replacing a shift due to an absence.

Review of PSW absence sign-in sheets for a six week period beginning mid April to May 2016, revealed that 26 PSW shifts had not been replaced.

Review of RPN absence sign-in sheets for a six week period beginning mid April to May 2016, revealed that 16 RPN shifts had not been replaced.

The current staffing plan further revealed that in the event the roster had been exhausted then the senior personnel must fill in.

Interview with staff #103 revealed there had been several registered staff and PSW shifts not covered over the past six weeks and that the home's current staff replacement process had not been successful in replacing shifts.

Staff #103 confirmed that the above mentioned staffing plan had not been evaluated and updated at least annually. [s. 31. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the staffing plan is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

In May 2016, observations by the inspector revealed two areas of altered skin integrity on identified body areas of resident #007.

Review of a specialized assessment completed by staff #144 on two identified dates in May 2016, revealed resident #007 had areas of altered skin integrity to other body areas but it did not indicate the above mentioned areas observed by the inspector.

Interview with staff #144 revealed that he/she had seen the above mentioned areas of altered skin integrity. Staff #144 further revealed that resident #007 has a history of causing altered skin integrity to him/herself.

Record review of the home's progress notes and treatment administration record (TAR) for resident #007 had not revealed any areas of altered skin integrity.

Interview with staff #101 revealed that he/she had not observed the above noted areas of

altered skin integrity on resident #007 and therefore had not completed the required assessment. Staff #127 further revealed that an assessment should have been completed on the home's assessment record form specifically designed for skin and wound.

Interviews with staff #112 and staff #103 confirmed an assessment had not been completed for resident #007 on a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity including skin breakdown, pressure ulcers, skin tears or wounds have been assessed by a registered dietitian who is a member of the staff of the home.

In May 2016, observations by the inspector revealed two areas of altered skin integrity to an identified body area of resident #007.

Review of a head to toe skin assessment completed by PSW #144 on two identified dates in May 2016, revealed resident #007 had areas of altered skin integrity to identified areas but had not indicated the above mentioned body areas of altered skin integrity.

Review of the most recent written plan of care had not revealed an assessment had been completed by RD #127 for the above mentioned areas of altered skin integrity.

Interview with RPN #101 revealed that he/she had not completed a referral to Registered Dietitian (RD) #127 to complete an assessment of above mentioned areas of altered skin integrity.

Interview with RD #127 confirmed that he/she had not received a referral for an assessment of resident #007 related to altered skin integrity. [s. 50. (2) (b) (iii)]

3. The licensee has failed to ensure that resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

a) The most recent written plan of care for resident #005 indicates that the resident had an identified area of altered skin integrity which required weekly wound assessments. Review of the weekly ulcer/wound assessment record from an identified date in December 2015 up to an identified date in May 2016, revealed the weekly wound

assessment had not been completed on a consistent basis and noted multiple uncompleted assessments between December 2015 to May 2016.

Interviews with the wound care nurse (WCN) #112 and DOC #103 confirmed that the home's expectation had been for the weekly assessments to be completed for resident #005.

b) Record review of resident #012's most recent written plan of care revealed that since December 2015, resident #012 had a new area of impaired skin integrity to an identified body area.

Record review of the physician orders on an identified date in January 2016, revealed wound assessments had been ordered to be completed weekly.

Interview with WCN#112 revealed that weekly wound assessments were to be completed every Wednesday using the home's weekly ulcer/wound assessment record primarily by the registered staff that regularly had been completing the dressing changes.

Review of resident #012's weekly ulcer/wound assessment record revealed that weekly wound assessments had not been completed on a consistent basis and noted multiple uncompleted assessments between February 2016 to May 2016.

Interview with registered staff #114 revealed that he/she had been routinely completing resident #012's dressing changes. Registered staff #114 also revealed that weekly wound assessments were to be completed every Wednesday and that he/she had not completed weekly wound assessments for resident #012 every Wednesday as ordered.

Interviews with WCN #112 and DOC #103 confirmed that resident #012's altered skin integrity had not been assessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

The licensee has failed to ensure that residents who require assistance with eating or drinking are only served a meal when someone is available to provide the assistance.

In May 2016, observations by the inspector revealed that resident #014 had been seated at the dining room table with his/her meal placed in front of him/her on the table for 20 minutes until a staff member came to assist with feeding.

Review of resident #014 most recent written plan of care revealed that resident #014 required total feeding by one staff.

On the same day the inspector observed resident #015 seated in the dining room with his/her meal placed on the table for approximately 15 minutes until a staff member came to assist with feeding.

Review of resident #015 most recent written plan of care revealed that resident #015 requires total feeding by one staff.

An interview with staff #112 confirmed that residents #014 and #015 required total assistance with feeding and that their meals should not have been served prior to staff becoming available to assist with feeding. [s. 73. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents who require assistance with eating or drinking are only served a meal when someone is available to provide the assistance, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Infection Prevention and Control program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Review of the homes Infection Prevention and Control Program revealed and interviews held with the infection control lead, staff #103 and staff #102 confirmed that the infection control program had been updated and revised however, the program had not been evaluated in 2015. [s. 229. (2) (d)]

2. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program.

a) In May 2016, observations by the inspector revealed staff #107 handling the garbage, then handling food items from the refrigerator without performing hand hygiene in between each task.

Interview with staff#107 confirmed that he/she had taken the garbage out and had forgotten to perform hand hygiene in between the two tasks.

Interview with staff #109 confirmed that staff #107 had not performed hand hygiene as required. He/she indicated the home's expectation is to wash hands during service using hand sanitizer, and after taking the garbage out, staff should wash hands with soap and water.,

Interview with staff #111 confirmed that he/she had not washed his/her hands changing gloves and revealed that he/she should have. Staff #111 then proceeded to use the hand

sanitizer.

b) In May 2016, observations by the inspector revealed staff #111 changing his/her disposable gloves while serving lunch to residents in the main dining room without performing hand hygiene in between each glove change.

c) Review of resident #010's laboratory results for specimens taken which revealed the resident had an infection.

Observations by the inspector revealed signage on resident #010's door indicated that staff were to use personal protective equipment when providing care to resident #010.

In May 2016, observations by the inspector on three identified dates revealed the infection prevention and control trolley for resident #010 had not contained an personal protective equipment.

Interview with staff #112 confirmed resident #010 had an infection and that personal protective equipment had not been available for staff use. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the Infection Prevention and Control program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

The licensee has failed to ensure that the home is a safe and secure environment for its

residents.

a) In May 2016, observations by the inspector revealed unlocked tub and shower room doors on identified areas of the home. The tub room located on the north side of the first floor had four bio-hazard totes stored against the wall. One of these totes contained filled sharps containers.

Interviews with staff #114 and #101 revealed that it had been the home's practice to store filled sharps containers in the bio-hazard totes located in the first floor tub room.

Interview with staff #102 and staff #103 revealed it had been the home's practice to close and not lock tub and shower room doors and to store bio-hazard totes in the above mentioned tub room as space is limited in the home.

Interview with staff #102 confirmed that by not locking tub and shower room doors and storing bio-hazard containers in the first floor north tub room, the home failed to ensure a safe and secure environment for its residents.

b) In May 2016, observations by the inspector revealed the elevator had not been equipped with a safety mechanism to prevent residents from accessing the basement unsupervised. Further observations revealed the physiotherapy and recreation rooms were located in the basement.

In May 2016, observations by the inspector revealed resident #056 was in the basement unsupervised. It was noted that he/she had been attempting to enter the elevator seated in a wheelchair and that the doors were closing on him/her. Further observations on the same day revealed resident #009 was in the basement unsupervised looking to attend the monthly birthday party scheduled at a later time that day.

In June 2016, observations by the inspector revealed resident #057 entering the elevator seated in a wheelchair unsupervised.

Interview with the staff #100 revealed resident #057 had been in a PT program and he/she had asked resident #057 to wait to be escorted back to his/her room. Staff #100 further revealed resident #057 had not waited and had proceeded to the elevator unsupervised.

Interview with staff #140 revealed that all residents are to be escorted to and from the PT

room in the basement.

Interview with staff #103 revealed and confirmed that residents are not to be in the basement unsupervised. [s. 5.]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (4) During the hours that an Administrator or Director of Nursing and Personal Care works in that capacity, he or she shall not be considered to be a registered nurse on duty and present in the long-term care home for the purposes of subsection (3), except as provided for in the regulations. 2007, c. 8, s. 8 (4).

Findings/Faits saillants :

The licensee has failed to ensure that during the hours that an Administrator or Director of Nursing and Personal Care works in that capacity, he or she shall not be considered to be a registered nurse on duty and present in the long-term care home for the purposes of section 8 (3) of the Act.

Review of two complaints submitted to the Ministry of Health and Long Term Care revealed concerns related to insufficient staffing.

Review of the home's absent call-in sheets over the past six weeks revealed several registered nurse (RN) shifts had been required to be replaced.

Interviews with staff #139 and staff #103 confirmed that over the past six weeks, staff #103 had assumed the roles of Nurse Manager and Registered Nurse on the following dates:
-March 2016, worked as the night RN in the home and subsequently did not work in the DOC role the next day,
-March 2016, worked as the day shift nurse manager,
-March 2016, worked as the day shift nurse manager,
-May 2016, worked as the night RN in the home
-May 2016, worked as the night RN in the home,
-April 2016, worked at the day shift nurse manager,
-May 2016, worked as the day shift nurse manager and,
-May 2016, worked as the day shift nurse manager.

Interview with staff #103 confirmed that during the hours that a Director of Nursing and Personal Care worked in that capacity, he/she had been considered to be the registered nurse on duty and present in the long-term care home for the purposes of section 8 (3) of the Act. [s. 8. (4)]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

The licensee has failed to ensure that a PASD that is used to assist a resident with a routine activity of living is included in the resident's plan of care.

Review of the most recent written plan of care had not included the use and/or purpose of the bed safety devices for resident #005 and throughout the inspection, inspector #116 observed two bed safety devices had been used with resident #005.

Interviews with RPN #119, PSW's #116, #118, and DOC #103 revealed and confirmed that resident #005 requires the use of the bed safety devices for assistance with mobility.

DOC #103 further confirmed that the bed safety devices in place were considered as PASD's and should have been included in the written plan of care for resident #005. [s. 33. (3)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(g) documentation on the production sheet of any menu substitutions. O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

The licensee has failed to ensure that the food production system at a minimum, provide for documentation on the production sheet of any menu substitutions.

Review of the Week-2 spring/summer menu for Thursday May 12, 2016, revealed an identified meal item had been planned for residents on specialized diets.

On May 12, 2016, during lunch service in the main dining room, the inspector observed resident #001 eating an identified meal item.

Review of resident #001's health record revealed he/she required a specialized diet related to underlying health conditions.

Interviews with DA #106 and cook #108 revealed the planned meal item had not been available and therefore had been substituted.

Review of the production sheets and interview with FSM #109 confirmed that the above mentioned food item had been substituted and that the substitution had not been recorded on the production sheets. [s. 72. (2) (g)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, contained procedures and interventions to assist and support residents who have been allegedly abused, or neglected.

Review of the home's "Abuse and Neglect", policy # 02-06, dated October 2015, failed to reveal procedures and interventions to assist and support residents who have been allegedly abused, or neglected.

Interview with ED #102 confirmed the above mentioned components had not been included in the home's policy that promotes zero tolerance of abuse and neglect of residents. [s. 96. (a)]

2. The licensee has failed to ensure that the written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, contained procedures and interventions to assist and support residents who have been allegedly abused, or neglected.

Review of the home's "Abuse and Neglect", policy # 02-06, dated October 2015, failed to reveal procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents.

Interview with ED #102 confirmed the above mentioned components had not been included in the home's policy that promotes zero tolerance of abuse and neglect of residents. [s. 96. (b)]

3. The licensee has failed to ensure that the written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, contained procedures and interventions to assist and support residents who have been allegedly abused, or neglected.

Review of the home's "Abuse and Neglect", policy # 02-06, dated October 2015, failed to identify measures and strategies to prevent abuse and neglect.

Interview with ED #102 confirmed the above mentioned components had not been included in the home's policy that promotes zero tolerance of abuse and neglect of residents. [s. 96. (c)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

The licensee has failed to ensure that when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

A CIS submitted to the Director in February 2016, revealed that resident #004 had struck resident #022 and resident #002 then reacted by causing an injury to resident #004. The incident was unprovoked and had occurred an identified number of times within the month.

Review of the progress notes for resident #004 from January to May 2016, revealed on seven identified dates in 2016, resident #004 had exhibited responsive behaviours towards co-residents and staff.

Review of the medication and treatment notes from January to May 2016, revealed resident had been given a medication and that the resident's response and the effectiveness of this medication had not been documented on an identified date in May 2016. The above mentioned medication had been given as needed (PRN).

Interview with NM #124 confirmed that the effectiveness of the medication had not been documented on the above identified dates.
[s. 134. (a)]

Issued on this 22nd day of November, 2016

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JOANNE ZAHUR (589), JULIENNE NGONLOGA (502), SARAN DANIEL-DODD (116), STELLA NG (507)
Inspection No. / No de l'inspection :	2016_353589_0011
Log No. / Registre no:	013953-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Oct 28, 2016
Licensee / Titulaire de permis :	ROYAL CANADIAN LEGION DISTRICT 'D' CARE CENTRES 59 Lawson Rd, TORONTO, ON, M1C-2J1
LTC Home / Foyer de SLD :	TONY STACEY CENTRE FOR VETERANS' CARE 59 Lawson Road, TORONTO, ON, M1C-2J1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	CATHERINE HILGE

To ROYAL CANADIAN LEGION DISTRICT 'D' CARE CENTRES, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Linked to Existing Order / Lien vers ordre existant: 2015_302600_0012, CO #004;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance with LTCHA s. 19 (1) to ensure residents are protected from abuse by anyone in the home.

The plan must include:
-The outline and implementation plans for a system of ongoing monitoring to ensure staff comply with the processes developed by the home to ensure all residents are protected from any form of abuse.
-Procedures and interventions to assist and support residents who have been allegedly abused, or neglected.
-A process to identify what measures and strategies should be taken to prevent staff to resident abuse and neglect and resident to resident abuse.

The plan is to be emailed to Joanne.Zahur@ontario.ca on or before November 11, 2016.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that residents are protected from physical abuse by resident #004.

In accordance with the definition identified in section 2(1) of the Regulation 79/10, "physical abuse" means the use of physical force by a resident that causes physical injury to another resident.

Record review of a critical incident system report (CIS) submitted in February

2016, revealed resident #004 struck resident #022 and resident #022 reacted by injuring resident #004.

Review of the Resident Assessment Instrument – Minimum Data Set (RAI-MDS) assessment dated September and March 2016, for resident #004 revealed the resident exhibits responsive behaviours.

Review of the progress notes from September 2015, to May 2016, revealed resident #004's behaviours included several responsive behaviours that he/she had been exhibiting towards other residents and staff. Behavioural Support Ontario (BSO) documentation revealed that resident #004 had been referred to the BSO team following an escalation in behaviours in September 2015.

Further review of the progress notes for resident #004 revealed he/she had been involved in the following altercations:
-January 2016, struck RPN #143 which caused discomfort and pain,
-February 2016, resident #004 struck resident #017, causing no apparent injury,
-February 2016, resident #004 in an identified gesturing motion, attempted to strike resident #017. Staff had documented that resident #004 appeared very angry,
-February 2016, the dosage of an identified medication had been increased as well as the timing of administration,
-February 2016, while in the dining room resident #004 struck resident #020 with no apparent injury sustained,
-February 2016, resident #004 struck resident #021 causing injury,
-February 2016, the dosage of a second identified medication had been increased and also the frequency of the as needed dose (PRN) had been increased,
-March 2016, resident #004 struck resident #019 with no injury sustained,
-May 2016, resident #018 reported to PSW #134 that resident #004 had hit him/her when he/she had tried to have a conversation with him/her and,
-May 2016, resident #017 had been sitting at the nursing station, visibly upset and reporting that he/she had been struck by resident #004 with no apparent injury sustained.

Interviews with staff #133 and staff #124 revealed resident #004 had been discharged from the BSO program in February 2016. Staff #133 further revealed that he/she had not been aware of several resident to resident altercations between February and May 2016.

Interview with staff #103 revealed due to resident #004's ongoing demonstration of responsive behaviours, the BSO team should not have discontinued their weekly assessments.

Based on the fact that there were several documented incidents of responsive behaviours with some resulting in injury to both residents and staff, and the BSO had discharged the resident from the program even though the resident continued to demonstrate responsive behaviours, the licensee failed to ensure the residents were protected from abuse by resident #004.

2. The licensee has failed to ensure that resident #004 had been protected from verbal abuse.

In accordance with the definition identified in section 2(1) of the Regulation 79/10, "verbal abuse" means any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

Record review of a CIS report submitted in September 2015, revealed resident #004 had been lying in bed incontinent. Staff #132 offered to wash and change the resident in the bathroom; however resident #004 was resistive and staff #132 was overheard raising their voice at resident #004 in a demeaning way.

Interview with staff #117 and staff #148 confirmed they had heard staff #132 raising their voice speaking in a demeaning way to the resident when suddenly they heard a noise and found resident #004 on the floor with an injury.

Interview with staff #132 confirmed providing care to the resident on the above identified dated, but denied raising their voice at the resident.

Interview with staff #102 confirmed resident #004 had been verbally abused by staff #132. Staff #102 further revealed that staff #132 had been disciplined and had not provided care to the resident since the incident.

LTCHA, 2007 s.19.(1) was issued as a compliance order (CO #004) during inspection #2015_302600_0012 on November 25, 2015, with a compliance order date of January 31, 2016. During the course of this inspection, inspector

#502 identified three residents that had been physically abused.

Due to actual harm, the scope of residents affected and the previous compliance history, a compliance order is warranted [s. 19. (1)] (502)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 23, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 28th day of October, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Joanne Zahur

Service Area Office /
Bureau régional de services : Toronto Service Area Office